DEPARTMENT OF HEALTH AND HU! SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 12/16/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A, BUILDING		(X3) DATE SURVEY COMPLETED	
	· · · · · · · · · · · · · · · · · · ·	09G118	B. WING		10	/25/2018
NAME OF	PROVIDER OR SUPPLIER		STI	REET ADDRESS, CITY, STATE, ZIP CODE	1 10	12012010
BEHAVIO	OR RESEARCH ASSO	CIATES	W/	ASHINGTON, DC 20019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFILIENCY)	D BE	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS		W 000			
	10/23/18 through 10 clients was selected males with varying of	on survey was conducted from 0/25/18. A sample of three d from a population of five degrees of intellectual rvey was conducted utilizing ess.				
	The findings of the sobservations, intervial administrative record	survey were based on riews and review of client and rds.				
	was in substantial correquirements of 42 (CFR 483, Subpart I, termediate Care Facilities. No				
					1	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

DEPARTMENT OF HEALTH AND HUI CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED	
		09G118			10/25/2018		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF		720/2010	
BEHAVIO	OR RESEARCH ASSO	DCIATES		WASHINGTON, DC 20019			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
E 000	Initial Comments		E 00	00			
	An emergency pre conducted from 10	paredness survey was /23/18 through 10/25/18.					
	requirements of En Requirements for M Participation for Int	substantial compliance with the nergency Preparedness Medicare and Medicaid ermediate Care Facilities for ellectual Disabilities (ICF/IID).					
	No deficiencies we	re cited.					
BORATORY	DIRECTOR'S OR PROVIDI	ER/SUPPLIER REPRESENTATIVE'S SIGN	JATURE	TITLE		(X6) DATE	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 12/16/2018 FORM APPROVED Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING HFD03-0079 10/25/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **BEHAVIOR RESEARCH ASSOCIATES** WASHINGTON, DC 20019 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) 1000 INITIAL COMMENTS 1000 A full licensure survey was conducted from 10/23/18 through 10/25/18. A sample of three residents was selected from a population of fives males with varying degrees of intellectual disabilities. The findings of the survey were based on observations, interviews, and reviews of resident and administrative records. The survey findings determined that the facility was in substantial compliance with the requirements of Title 22 Public Health and Medicine Chapter 35 Group Homes for Individuals with Intellectual Disabilities. No deficiencies were cited.

Health Regulation & Licensing Administration LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE